STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING: _____ B. WING _____	02/24/2020

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4 000	Initial Comments A re-licensure survey conducted by the Office of Health Care Assurance was completed on February 24, 2020. The facility reported census was 113 residents at time of entrance.	4 000		
4 102	11-94.1-22(d) Medical record system (d) Records to be maintained and updated, as necessary, for the duration of each resident's stay shall also include: (1) Appropriate authorizations and consents for medical procedures; (2) Records of all periods, with physician orders, of use of physical or chemical restraints with justification and authorization for each and documentation of ongoing assessment of resident during use of restraints; (3) Copies of initial and periodic examinations and evaluations, as well as progress notes at appropriate intervals; (4) Regular review of an overall plan of care setting forth goals to be accomplished through individually designed activities, therapies, and treatments, and indicating which professional services or individual is responsible for providing the care or service; (5) Entries describing all care, treatments, medications, tests, immunizations, and all ancillary services provided; and (6) All physician's, physician assistant's, or APRN's orders completed with appropriate documentation (signature, title, and date).	4 102		4/10/20

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4 102	Continued From page 1 This Statute is not met as evidenced by: Based on observation, staff interviews, the facility failed to ensure the medical records were complete for 2 of 10 sampled resident, (R)41 and R66, and accurate documentation for 2 of 10 sampled residents, R113 and R41. Failure to have orders authenticated in a timely manner could potentially contribute to medical errors associated with communication and transcription of the actual content of the physician orders. Failure to accurately document administration of medication could potentially contribute to medication administration errors. Failure to accurately document the application of the use of a splint for R41 contributed to contracture progression as evidence by the facility not identifying and appropriately referring R41 to rehabilitation services when staff was unable to properly apply R41's right-hand resting splint. Findings include: A record review conducted on 02/19/20 and 02/21/20, multiple resident's medical records contained multiple red post-it like sticker indicating the Physician needed to sign the Telephone/Verbal order: 1) Resident (R)41's medical chart contained multiple orders not sign. Two examples of orders not signed were: "2/19/20 D/C Bactracin" and "2/2/20, UTI- Rocephin (unledgeable number) mix with 2.1 ml lidocain daily. Dx: UTI." Additionally, the activity sheet which documents the activity the resident participated in, documented R41 watched television, daily, as an activity. Activity staff (AS) confirmed R41 listened to the radio and R41 did not have access to watch a television.	4 102	11-94. 1-22(d) Medical Record System (1)Part 1 1. Resident R41's Physician Orders were signed on 3/20/2020 at 1230hours. On 03/31/20, the Director of Nursing reviewed the facility policy and procedure on how to carry out Physician Orders. Educated all Nursing Staff on 04/09/20 to follow the 5 Rights of Medication Administration. 2. The Director of Nursing will continue to in-service Licensed Nurses on facility policy and procedure on how to carry out Physician Orders and medication administration, including the 5 Rights of Medication Administration. All charts were audited by Medical Records to ensure orders were signed. Any missing signatures were immediately addressed by the appropriate physicians on 04/06/20. 3. The Nursing Supervisor will review resident Medication Administration Records weekly and develop a tracking tool to monitor for and ensure completion. Going forward, the Health Information Associate will be checking all orders daily to ensure they have been signed. Any orders not signed by the appropriate	

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4 102	Continued From page 2 2) R66 order in the medical chart that were not signed included "2/13/20 Hold Novolin N 2 Units SQ @ 0600 today, Give Novolin N 2 Units SQ @ 1800 today." Additionally the January & February 2020 Physician's Order Sheet was not signed. 3) On 2/20/20 at 08:45 AM, observed R34 administer medications (Calcium/Vit D 500 mg/400 IU; Docusate Sodium 1100 mg; Ferrous Sulfate 325 mg; and Sodium Chloride 500 mg) to R113. Reviewed the medication administration record (MAR) at at 10:25 AM, R34 did not sign the MAR, which indicates the medications were administered. 4) Cross reference with FTag 684 Review of R41's Care Plan: Restorative Care Plan documented, "Resident has actual contractures/impaired functional range of motion of: Bilateral Hands related to TBI (Traumatic Brain Injury). The Care plan goals were: Resident will not experience contracture progression as evidenced by continued ability to wear current splints comfortably and without complication; Resident will not experience any complications related to wearing splint" with a target date of 03/19/20. Interventions implemented for R41's Restorative Splinting Program includes applying resting hand splints to both hands: on for 6 hours; off 18 hours; apply at 09:00; remove at 15:00; and refer to therapy as needed. Throughout the survey (02/18- 24/20) multiple observations (02/18/20 at 10:57 AM, 01:45 PM, and 02:30 PM; 02/19/20 at 09:14 AM, 10:35 AM, and 02:45 PM; 02/20/20 at 10:58 AM and 01:15 PM; 02/21/20 at 10:07 AM and 02:15 PM; 02/24/20 at 09:00 AM) were made of R41 with no right-hand splint applied as indicated by the care	4 102	physicians will be brought to the attention of the Medical Director who will respond accordingly. 4. Consistent issues with physician signing orders in a timely manner will be brought to the Medical Director's attention so that they may speak with the physician. Discrepancies and non-compliance will be reported to the quarterly QA Committee meetings by the Health Information Associate or designee. (1) Part 2 1. Resident R41, Activity staff made documentation error on resident activity sheet, noting watching television daily rather than listening to radio daily. Correction was immediately made to document. Resident has radio at bedside which Activity staff ensure is working properly and turned on for listening purposes that reflect resident's preferences. 2. Activity staff reviewed their documentation to ensure correct activities and needs of all residents were being addressed and were properly reflected in the documentation. Assessments are completed on admission, quarterly, annually and if there is a significant change in a resident's condition. Activities should be reflective of residents' personal preferences, abilities, and contribute to	

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4 102	Continued From page 3 plan. On 02/24/20 at 09:00 AM, Restorative Staff (RS)2 confirmed resting hand splint was not applied to R41's right hand, due to worsening of (R41's) contracture of the right hand and the splint not longer fits the resident. Reviewed of R41's February 2020 Treatment Administration Record (TAR), initialed by the licensed nursing staff, and February 24, 2020 ADL (activity of daily living) Flowsheet, initialed by the restorative staff, with RS2. Facility staff documented on both, TAR and ADL Flowsheet, resting hand splints were applied to both hands, which contradicted observations made by this surveyor. RS2's confirmed the discrepancy between observations made by this surveyor and staff documentation of the right hand splint being applied by staff. RS2 stated R41 has not been able to wear the right-hand resting splint for "a month or so" and could not confirm a specific date or time staff stopped applying the splint. On 02/24/20 at 09:44 AM, inquired with the Director of Nursing (DON) regarding observations made by this surveyor, contracture progression for R41, and the accuracy of staff documentation. DON explained, residents who are on the RNA Program are visually and verbally reviewed monthly by multiple disciplines (DON, RNA, RN, and PT) for progress, status and the need for physical/occupational/speech therapy referrals. Reviewed "Monthly RNA Meeting" with DON held on 02/07/20. The monthly meetings report, documented R41's current treatment program "PROM (passive range of movement) BLE (bilateral lower extremity) 4 times a week; B (bilateral) resting hand 5 times per week" was reviewed and continued with no changes. DON could not recall if R41 wore the right-hand resting splint at the time of the monthly meeting and	4 102	enhancing their quality of life. Any changes discussed at the quarterly Care Conferences are communicated to the Activity Department to ensure preferences are updated. Any other changes to resident preferences outside of Care Conferences will be updated on the resident activity sheet as the change occurs. 3. Audits will be done monthly on Activity logs for accuracy by Activities Coordinator or designee. 4. Activity compliance with correct paperwork completion will be reported to Quarterly QA Meeting by Activities Coordinator or designee. (2) 1. For R66, whose order and POS was found to have been affected by the deficient practice, their physician was immediately contacted and the missing signatures were obtained. 2. Physicians will be notified in writing as to Pearl City Nursing Home□s Policy & Procedure regarding Medical Records in relation to Telephone Orders, Legibility, and Physicians Order Sheet. All physicians will be oriented to the policy and procedure of PCNH regarding Telephone Orders, POS and legibility. Attending physicians will each be designated a color specific binder. These	

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4 102	Continued From page 4 confirmed R41's contracture progression was not identified. DON further explained, if a change is identified residents are referred for rehab services. Also, DON confirmed staff should not document application of the splint if it was not applied. Accurate documentation is essential in the identification of contracture progression and the need for rehab referral to prevent contracture progression for R41.	4 102	binders will have a designated tab for the POS□ requiring signatures from the physicians. The binders will also have a clear binder pouch in which the Telephone Orders will be placed. The facility will ensure that all further Phone orders must be counter-signed by the attending physician on their next visit. (Per Department of Health Hawaii State Regulations □ Chapter 94). Any missed or unsigned telephone orders during the physician□s visit will be faxed to the Physician□s Office immediately for signature. 3. The unit clerks will monitor the physician binders for signed telephone orders and POS and will file completed documents into the appropriate resident medical records in a timely manner. All POS will be audited by The Unit Clerk on the third week of every month. Any unsigned POS will be placed in the respective Physician□s Binder for signature. 4. Health Information Supervisor will audit monthly and report compliance to the Quarterly QA Meeting. (3)1) R34 Mar signed on 3/20/2020 at 1230hours. Director of Nursing reviewed the Facility Policy and Procedure on how to carry out Physician orders. Educated all Nursing Staff to follow the 5 Rights of Medication Administration.	

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4 102	Continued From page 5	4 102	2) Director of Nursing will continue to in-service Licensed Nurses on Facility Policy and Procedure on how to carry out Physician Orders and Medication Administration, including the 5 Rights of Medication Administration. 3) RN Supervisor will review resident Medication Administration Records weekly and develop a tracking tool to monitor for and ensure completeness, and ongoing. 4)Director of Nursing or Designee will report all compliance and non-compliance to Quarterly QA Committee. (4)1. Thin cloth applied on (R41) resident□s right hand as a barrier between palm and fingers. Occupational Therapy Screen requested. 3/2/2020 □ Order made to Occupational Therapy for re-evaluation/treatment of right hand contracture management. Implementation delayed due to pending insurance approval. Approval received from insurance 3/9/2020. 3/9/2020 □ OT treatment was started 2x/week for 60 days. Stretching is being performed until a specific, appropriate hand splint device is determined. Resident care plan and treatment documentation updated. 2. Upon admission and daily, all residents will be assessed by Nursing Staff for presence of contracture. Residents identified will be referred to OT for	

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4 102	Continued From page 6	4 102	screening to determine if contracture management is necessary. Restorative Nursing Assistant will discuss residents who have contracture and splint managment and at risk residents at every monthly RNA meeting. Nursing Staff will continue to assess residents with potential for contracture daily and on going. 3. Education and in-service being provided to Nursing Staff, and RNA on how to determine and assess residents with contractures and on the correct application of hand splints and documentation. Any difficulty to apply a splint will be reported to Charge Nurse immediately for referral to OT for further management. Resident will be discussed at next monthly RNA meeting and ongoing. 4. Licensed Nurses assigned to resident will supervise the application of hand splint, RN Supervisor will double check the application to ensure compliance per care plan is achieved. Director of Nursing or Designee will track the list of residents with contracture/hand splint application every month and report compliance to Quarterly QA.	
4 113	11-94.1-27(2) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or	4 113		4/10/20

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4 113	Continued From page 7 representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (2) The right to be free of interference, coercion, discrimination, and reprisal from the facility that shall include the right to be free of chemical or physical restraints not medically indicated; This Statute is not met as evidenced by: Based on observation, record review (RR), and interviews, the facility did not consider grab bars (GB) to be siderails, so failed to have a process in place to educate resident/representatives of the risks of GB and obtain consent for use. Two residents (R) 416 and R20 of two sampled had GB installed and did not have consent or documentation of education prior to installation of the GB. This deficient practice affects all residents who had GB installed. Findings include: 1. R416 was admitted to the facility on 01/22/20 from an acute care hospital for short term rehabilitation. She is independent with self care and mobility in bed. On 02/21/20 at 09:02 AM, observed bilateral GB on R416's bed. RR revealed "Bed Rail Entrapment Assessment" form was completed on 01/25/20. There was no documentation in the medical record that R416 had been informed of the risks and benefit of the GB and there was no documentation of informed consent. 2. R20 is 98 years old and was admitted to the facility on 08/14/18. He is non ambulatory and	4 113	11-94.1-27(2) (1), (2), (3), (4) 1. Reviewed facility Policy and Procedure for Bedrail and Assist Rails. Per Policy and Procedure, Assist Rails are indicated and not a Grab Bar for resident assistance for bed mobility. Informed Consent form has been revised to include Risks and Benefits for the use of Bedrails/Assist Rails. Bedrail/Assist Rail assessment tool has been modified to include resident and family education. All residents, including R416 and R20, are being reassessed for Bed Rail/Assist Rail needs. 2. All residents upon admission will be assessed by Nursing Staff as part of the admission process for the need of bedrail/assist rails. Subsequent assessments will be done quarterly, annually and for resident significant change. If a need is indicated by assessment, the Risks and Benefits Consent form will be discussed with family and or responsible party and signed. A Physician order will be obtained and Care	

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4 113	Continued From page 8 needs assistance with all activities of daily living. On 02/19/20 at 08:29 AM observed bilateral GB on R20's bed. RR revealed a "Bed Rail Entrapment Risk Assessment form completed on 07/08/19. The form had the following notations on it: "Note: Use 2 upper grab bar for, mobility and positioning... In use during bed mobility and repositioning only." The question on the assessment form, "Has the decision to use or not use bedrails been discussed with the responsible party?," was checked "No." R20's care plan (CP) included the problem, " Resident uses 2 upper grab bars for bed mobility." The interventions included; "release restraints every 2 hours during ...", which did not apply to R20. The CP also include "Obtain informed consent." There was no documentation of informed consent in the medical record. 3.On 02/20/20 at 08:28 AM during an interview with the Nursing Supervisor (NS)1 for the second and third floor, she said, "We do not have consents for GB. We get consents for half and full rails, or lap belts. GB need doctors' orders to initiate and we do a nursing assessment for bed mobility and positioning in bed." Asked if education provided to the resident/representative of the risks and benefits of the GB is documented, she said no. The facility did not have an informed consent for the use of GB and does not review the risks of GB use with resident/representatives. 4. On 02/24/20 at 08:18 AM during an interview with the Director of Nursing (DON), asked what the current practice was for bedrails/GB. DON stated, "We do an assessment on admission and determine with residents or families if they will be used. We recommend no siderails but	4 113	Plan will be initiated. 3. Director of Nursing will in-service Nursing staff regarding the revision of the Informed Consent Risks and Benefits form and procedure of Bedrail/Assist rails. RN Supervisor will monitor the completion and accuracy of the Bedrail/Assist rails which includes upon admission, annually, quarterly and if resident has a significant change. 4. Director of Nursing or designee will monitor the tracking tool for Bedrail/Assist rails completion every month. A compliance report will be submitted to the Quarterly QA meeting.	

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4 113	Continued From page 9 sometimes they want them or need them for mobility." When asked if they consider a GB to be a side rail and document risks with consent, the DON said, "Grab bars currently are not considered a siderail, so we don't get consent."	4 113		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to ensure staff applied Resident (R)41's right-hand resting splint according to the resident's person-centered care	4 149	11-94. 1-39(b) Nursing services 1. Thin cloth applied on Resident R41's right	4/10/20

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4 149	Continued From page 10 plan. As a result of this deficiency, R41 experienced contracture progression as evidence by R41's continued inability to wear current right-hand resting splint. Cross reference with F842 Findings include: R41 is a 25 years old and was admitted to the facility on 12/05/18. A review of R41's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/10/2019 documents R41's active diagnoses include: Deep vein thrombosis (DVT), Pulmonary embolism (PE), or pulmonary thrombo-embolism (PTE); Hypertension; Aphasia; Quadriplegia; Seizure disorder or epilepsy; Traumatic brain injury (TBI); Respiratory failure; Obstructive hydrocephalus; Unspecified intracranial injury without loss of conscious, subsequent encounter; Encounter for gastrostomy; Retention of urine; Cerebral infarction; Acute bronchitis; and Dysphagia. R41 is totally dependent on staff for bed mobility, transferring, personal hygiene, always incontinent of bowel, and has an indwelling catheter. Additionally, R41 receives nutritional intake via tube feeding and has a tracheotomy. R41 is unable (rarely/never) to make needs/self understood and is unable (rarely/never) to understand others. Review of R41's Care Plan: Restorative Care Plan documented, "Resident has actual contractures/impaired functional range of motion of: Bilateral Hands related to TBI (Traumatic Brain Injury). The Care plan goals were: Resident will not experience contracture progression as evidenced by continued ability to wear current splints comfortably and without complication; Resident will not experience any	4 149	hand as a barrier between palm and fingers. An Occupational Therapy screen was requested. On 03/20/20 an order was made for Occupational Therapy for re-evaluation / treatment of right-hand contracture management. Implementation delayed due to pending insurance approval. Approval received from insurance on 03/09/20. On 03/09/20, treatment was started twice a week for 60 days. Stretching is being performed until a specific, appropriate hand splint device is determined. Resident care plan and treatment documentation updated. 2. On 04/10/20 all residents were assessed by the Director of Nursing and Nursing Supervisors to determine if splints were present and applied properly per therapy recommendations. A new system was developed for staff to easily identify if a resident should be wearing splints and the schedule for splinting. The new system involves the use of colored dots to determine if the splints should be applied to the upper or lower extremities, and what side, left or right. The splinting schedule is also being reviewed by the therapists to determine is a simpler schedule can be developed. This new log sheet will be kept by the resident's bedside for easy reference by staff. All residents to be completed by 04/14/20.	

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4 149	Continued From page 11 complications related to wearing splint" with a target date of 03/19/20. Interventions implemented for R41's Restorative Splinting Program includes applying resting hand splints to both hands: on for 6 hours; off 18 hours; apply at 09:00; remove at 15:00; and refer to therapy as needed. Reviewed R41's medical chart. "Occupational Therapy Upper Extremity Splint Schedule" includes directions of application/removal times (09:00 AM/ 03:00 PM) regarding splint usage. Throughout the survey (02/18- 24/20) multiple observations (02/18/20 at 10:57 AM, 01:45 PM, and 02:30 PM; 02/19/20 at 09:14 AM, 10:35 AM, and 02:45 PM; 02/20/20 at 10:58 AM and 01:15 PM; 02/21/20 at 10:07 AM and 02:15 PM; 02/24/20 at 09:00 AM) were made of R41 with no right-hand splint applied as indicated by the care plan. On 02/24/20 at 09:00 AM, Restorative Staff (RS)2 confirmed resting hand splint was not applied to R41's right hand, due to worsening of (R41's) contracture of the right hand and the splint not longer fits the resident. On 02/24/20 at 08:40 AM, inquired with Occupational Therapy staff (OT)1 regarding R41's bilateral resting hand splints. OT1 produced and reviewed R41's "OT- Therapist Progress & Discharge Summary" dated 05/24/19 and signed by OT2, which documented on, "Start of Goal Status as of 02/15/2019, Tolerates BUE(bilateral upper extremity) resting hand splints for 4 hours; Prior level as of 05/03/2019, Tolerates B (bilateral) resting hand splints for 6 hours; End of Goal Status as of 02/24/2019, Tolerates B (bilateral) resting hand splint for 6 hours." OT1 confirmed facility staff's inability to apply the resting hand splint to R41's hand would	4 149	3. Upon admission and daily, all residents will be assessed by the Nursing staff for presence of contracture. Residents identified will be referred to OT for screening to determine if contracture management is necessary. Restorative Nursing Assistants (RNA) will discuss residents who have contractures, splint management, and at-risk residents at every monthly RNA meeting. Nursing staff will continue to assess residents with potential for contracture daily and ongoing. 4. Education and in-service provided on 04/09/20 to Nursing staff and RNA on how to determine and assess residents with contractures and on the correct application of hand splints and documentation. Any difficulty to apply a splint will be reported to the Charge Nurse immediately for referral to Occupational Therapy for further management. Resident will be discussed at the next monthly RNA meeting and ongoing as necessary. 5. Licensed nurses assigned to the resident will monitor the application of hand splints. The Nursing Supervisor will check the application of hand splints daily x two weeks, then weekly x two months, then randomly audit to ensure compliance per Care Plan is achieved. The Director of Nursing or designee will track the list of residents with contracture / hand splint application every month and report	

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4 149	Continued From page 12 indicate a contracture progression and staff should document and evaluate the progression of the contracture to assess for the resident's need for therapy services. OT1 also confirmed there was no record R41 had been referred for therapy services by the facility after R41's discharge from physical therapy on 09/17/19. Reviewed of R41's February 2020 Treatment Administration Record (TAR), initialed by the licensed nursing staff, and February 24, 2020 ADL (activity of daily living) Flowsheet, initialed by the restorative staff, with RS2. Facility staff documented on both, TAR and ADL Flowsheet, resting hand splints were applied to both hands, which contradicted observations made by this surveyor. RS2's confirmed the discrepancy between observations made by this surveyor and staff documentation of the right hand splint being applied by staff. RS2 stated R41 has not been able to wear the right-hand resting splint for "a month or so" and could not confirm a specific date or time staff stopped applying the splint. On 02/24/20 at 09:44 AM, inquired with the Director of Nursing (DON) regarding observations made by this surveyor, contracture progression for R41, and the accuracy of staff documentation. DON explained, residents who are on the RNA Program are visually and verbally reviewed monthly by multiple disciplines (DON, RNA, RN, and PT) for progress, status and the need for physical/occupational/speech therapy referrals. Reviewed "Monthly RNA Meeting" with DON held on 02/07/20. The monthly meetings report, documented R41's current treatment program "PROM (passive range of movement) BLE (bilateral lower extremity) 4 times a week; B (bilateral) resting hand 5 times per week" was reviewed and continued with no changes. DON	4 149	compliance to the quarterly QA Committee meeting.	

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4 149	Continued From page 13 could not recall if R41 wore the right-hand resting splint at the time of the monthly meeting and confirmed R41's contracture progression was not identified. DON further explained, if a change is identified residents are referred for rehab services. Also, DON confirmed staff should not document application of the splint if it was not applied. Accurate documentation is essential in the identification of contracture progression and the need for rehab referral to prevent contracture progression for R41.	4 149		
4 158	11-94.1-40(f) Dietary services (f) The facility shall have a food service plan documented and available for department review that shall include but not be limited to the following: (1) Menus shall be written at least one week in advance; (2) Menus shall provide a sufficient variety of foods served in adequate amounts at each meal, and be adjusted for seasonal changes along with resident preference; (3) A different menu shall be followed for each day of the week. If a cycle menu is used, the cycle shall cover a minimum of four weeks; (4) All menus shall be filed and maintained with any recorded changes for at least three months; and (5) Menus shall be in place for at least three to five days of meal service in case of a natural or external disaster. A plan for meal service in the event of an internal disaster such as interruption	4 158		4/10/20

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4 158	Continued From page 14 of power or water supply shall also be in place and available for departmental review. This Statute is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to facilitate Resident (R)39's food preference as evidence by R39 not receiving mash potatoes for meals as requested and documented. As a result of this deficiency, R39 is at an increased risk for potential negative physical and psychosocial outcomes. Findings include: R39 was admitted to the facility on 11/22/19. A review R39's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/29/19 documented admitting diagnoses which included "Malnutrition (protein of calorie) or at risk for malnutrition". The MDS also documented R39 weighed 96 lbs (pounds) and had a weight loss of 5% or more in the last month of loss of 10% or more in the last 6 months and was not on a physician-prescribed weight-loss regime. A review of the dietician's progress notes documented R39 requested mash potatoes and gravy for meals. The dietician took appropriate action to comply with the resident's request. On 02/18/20 at 11:30 AM, R39 reported to this surveyor he/she does not receive mash potatoes and gravy for meals consistently. The resident confirmed the "ticket", describes the contents of the meal, documents the resident should receive mash potatoes and gravy. R39 expressed feeling upset regarding the resident's food preferences and stated, "it's the only thing I really feel like eating and I need to put on some weight."	4 158	11-94.1-40(f) Dietary Services 1. Resident R39 at lunch meal service did not receive mashed potato with gravy that was indicated on his meal ticket. Nursing immediately notified kitchen and kitchen staff prepared and sent mashed potato with gravy to resident. 2. Each meal service, kitchen staff will check off the items on meal card before putting resident meal trays inside meal delivery cart. Nursing/Activity staff will double check meal card before service meal trays to residents. 3. Daily check off system will be implemented. Cook will record any call backs from resident units for compliance tracking. All food service personnel were inserviced to new protocols. Inservice completed 3/20/2020. 4. 100% compliance to be achieved monthly. Food Service Director to report compliance to Quarterly QA meeting.	

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4 158	Continued From page 15 On 02/18/20 at 12:45 PM, observed R39's lunch which consisted of minced carrots, yakisoba, fruits, gravy, and fluids. R39 did not receive mash potato for lunch and stated, "I never know if I will get mashed potatoes to eat. Sometimes I get it, sometimes I don't. What am I supposed to put the gravy on? Look at this other food, it doesn't look like it taste good. I don't want to eat it." The ticket which was delivered with lunch documented "Starch/Bread: MASH POTATO WITH GRAVY." Food service staff (FSS)4, certified nurse aide (CNA)2, and Licensed Practical Nurse (LPN)77 all confirmed the ticket which was on R39's tray documented the resident should have received mash potatoes for lunch, however, it was not on the lunch tray.	4 158		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observations, staff interview, review of policy, and review of food storage guidelines, the	4 159	4159 11-94.11-4(a)Storage and Handling of	4/10/20

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4 159	Continued From page 16 facility failed to properly store the following frozen food items: Shrimp dumplings, Japanese style noodles, and an unmarked bag of seafood. As a result of this deficient practice, the facility put the residents at risk of being exposed to poor food quality and/or contaminated food. Findings Include: During an observation of the kitchen walk-in freezer on 02/18/20 at 08:07 AM, a bin that contained several packages of Shrimp dumplings, several packages of Japanese style noodles, and an unmarked bag of seafood was noted to be on the floor. On 02/18/20 at 08:07 AM, Food Service Staff (FS) 1, who accompanied the above observation was queried and acknowledged that the bin of food should not have been stored on the floor. A review of the facility policy on storing refrigerated/frozen/dry goods of produce stated the following: Policy, to maintain quality in our foods that will be kept safe to consume by residents and staff. Procedures, refrigerated/freezer items will follow United States Drug Administration (USDA) Food Safety fact sheet. Also, staff will follow Association of Nutrition and Foodservice Professionals (ANFP) food storage guidelines for fruits, vegetables, and dry goods. A review of the ANFP Standards of Practice, Food Storage Guidelines revealed that food should be stored off the floor, specifically at least six inches above the floor.	4 159	Food 1. Items left on floor were discarded in trash immediately after they were found. 2. Am/Pm Cooks will monitor kitchen walk in daily, 5 times per day. Morning Cook will check freezer at start of shift 4:30am and before leaving shift 1pm. Night Cook will check 11am before start of shift , 3pm before break, by 7:30pm before end of shift. Staff Inservice completed 3/27/20 3. Food Service Director or PM cook will initial morning cook checklist before end of shift. PM cook will have PM Diet Aide initial that it has been done for night shift. Checklist will then be left on office desk for Food Service Director to review. Goal is 100% compliance monthly with ANFP Standards of Practice, Food Storage Guidelines. 4. Food Service Director to report compliance at Quarterly QA meeting.	

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4 172	Continued From page 17	4 172		
4 172	11-94.1-42(j) Physician services (j) Each resident shall receive age-appropriate immunizations or vaccinations including but not limited to pneumococcal and annual influenza vaccines and any necessary immunizations following the recommendations of the Advisory Committee of Immunization Practices unless otherwise contraindicated, or refused by the resident, legal guardian, or surrogate. All immunizations provided shall be documented in each resident's medical record. This Statute is not met as evidenced by: Based on interviews and record review (RR), the facility failed to assess one resident (R)20 of five sampled for administration of the pneumococcal vaccine to minimize the risk of acquiring, transmitting and experiencing complications from pneumococcal disease. As a result of this deficient practice, it put R20 at higher risk of acquiring pneumonia. Findings include: R20 is 98-year-old with hearing impairment, mild dementia, chronic anemia, and malnutrition. He was admitted to the facility 08/14/18, and is at high risk for infection due his age and medical history. Review of facility policy procedure titled "Pneumococcal Vaccine" dated August 2016, revealed the policy statement was: "All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections." The policy states "Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal	4 172	4172 11-94.1-42(j) Physician Services 1. Resident R20 Pneumonia vaccine was documented in resident□s chart. Attending Physician was consulted and after review did not recommend another dose due to resident□s advanced age and contraindication with his current medical condition. 2. Upon admission, all residents Pneumococcal and other vaccine histories will be obtained and recorded. Vaccines will be offered to Residents who do not have the vaccines and MD order will be obtained to administer unless refused or contraindicated. 3. Upon admission Nursing staff will review the resident□s history of Pneumococcal vaccine and record it in their immunization log. Residents who have no vaccine record will be offered vaccines and administered per Physicians	4/10/20

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4 172	Continued From page 18 vaccination protocol," and "Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. RR of R20's medical records, revealed no documentation that R20 had received a pneumococcal vaccine. On 02/24/20 at 01:14 PM, the Director of Nursing said she had called the physician's office and had obtained documentation that R20 had received a pneumococcal vaccine at an acute care hospital on 04/23/1987. Prior to this, there was no documented attempt to obtain R20's history of pneumococcal vaccination. On 02/24/20 at 02:00 PM, during an interview with the Administrator she agreed R20's medical record should have included his pneumococcal vaccination status and he should have had a documented assessment for revaccination according to CDC guidelines.	4 172	order unless refused or contraindicated. Nursing staff in-serviced to review the P&P for Pneumococcal vaccine implementation and education is ongoing. 4. Director of Nursing or designee will continue to monitor the completion of Pneumococcal Immunization Records. The completed list will be reviewed monthly and compliance will be presented at the Quarterly QA meeting.	
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that: (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions	4 185		4/10/20

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4 185	Continued From page 19 and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs; (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented. This Statute is not met as evidenced by: Based on observations, staff interviews, and a review of facility policy's and procedures, the facility failed to ensure medications were properly destroying unused medications. As a result of this deficiency, staff and the community is at risk for accidental exposure to controlled medications. Findings include: On 02/20/20 at 09:30 AM, inquired with multiple staff registered nurse (RN)17, RN6, RN34 and Licensed Practical Nurse (LPN)4 who are responsible for administering medications, regarding the disposal of medications (included controlled medications). Interviewed staff reported medications are either crushed and placed down the sink or put into the sharp container as a means of disposal. Staff confirmed patches (of medication/nicotine) are disposed of by cutting the patches up into pieces and placing the pieces into the sharps container and if the medication is dissolvable, staff with crush the medication and wash it down the sink. Inquired with staff interviewed regarding the use of a product (e.g., Rx Destroyer) by the facility to safely dispose of the medication. Interviewed	4 185	11-94.1-46(b) Pharmaceutical Services 1. The Director of Nursing reviewed the facility policy and procedure for medication disposal on 03/01/20 and provided to the survey team the newest policy on 04/07/20. Per policy, all medication in the form of tablet, liquid, and ointment will be dissolved in hot water, poured into a disposable diaper, then placed in a plastic bag and deposited into a bio-hazard waste container. Controlled substance medication is being disposed in the presence of two licensed nurses following the same procedure as other forms of medication. They are then documented in the Medication Disposal Log. The resident's name and medication information will be written in the controlled substance Medication Disposal log. 2. When a resident medication is discontinued, medication will be	

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4 185	Continued From page 20 staff confirmed they do not use a product (e.g., Rx Destroyer) to dispose of medication. During an inspection of the medication storage room on the 4th floor, this surveyor along with nursing staff were unable to find/locate a chemical digestive agent. A review of the facility's policy's and procedure for medication disposal documents, "A non-retrievable disposal method must be used....chemical digestion (for example, Rx Destroyer, Drug Dispose All, Drugbuster) or incineration. On 02/24/20, the Director of Nursing (DON) confirmed staff should be using a chemical agent to properly dispose of medications and did not produce a product to validate the use of a product.	4 185	immediately disposed following the facility policy and procedure. The Medication Disposal Log will be reviewed by the Nursing Supervisor within 72 hours of disposal to ensure that the process is being followed and completed according to the facility policies. 3. The Director of Nursing will in-service all licensed staff about the facility Medication Disposal policy and procedure on 04/09/20. 4. The Director of Nursing or designee will monitor the Medication Disposal Log completion record and randomly audit medication disposal if available once a week x four weeks, then once a month x three months, then quarterly x one year. Any discrepancies will be reported by the Director of Nursing or designee at the quarterly QA Committee meetings.	
4 194	11-94.1-46(k) Pharmaceutical services (k) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. This Statute is not met as evidenced by: Based on observation, record review, staff interview, and policy review, the facility failed to monitor the temperature controls for the medication refrigerator located on the third-floor nursing unit. This deficient practice put the residents at risk for adverse reactions from	4 194	11-94.1-46(k) Pharmaceutical Services 1. Medication Refrigerator temperature Log was reviewed by Director of Nursing on 2/26/2020 Nursing staff was in-serviced on the	4/10/20

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4 194	Continued From page 21 possible improper storage of medications. Findings Include: On 02/20/20 at 08:17 AM, during an observation and review of temperature monitoring records for the third-floor medication refrigerator, temperatures were not recorded for nine days of the past six months reviewed. The nine days were the following: 08/16/19, 09/07/19, 09/12-13/19, 10/25-26/19, 11/26/19, 12/29/19, 01/08/20. During staff interview with Registered Nurse (RN) 24, on 02/20/20 at 08:25 AM, RN24 stated that the temperatures for the refrigerator should have been monitored on a daily basis. During staff interview with Unit Manager (Mgr) 3 on 02/20/20 at 09:00 AM, Mgr3 acknowledged that the refrigerator temperatures were not recorded for the nine days as previously mentioned and should have been monitored each and every day. A review of facility policy on Medication Storage stated the following: Medications requiring refrigeration are kept in a refrigerator at temperatures between 2°C (36°F) and 8°C (46°F) with a thermometer to allow temperature monitoring. Medications requiring storage "in a cool place" are refrigerated unless otherwise directed on the label ... Medications that should be frozen should be stored in the freezer at 14°F (-4°C) to -20°F (-10°C). The facility should maintain a temperature log in the storage area to record temperatures at least once a day.	4 194	importance of daily temperature log completion. New revision of the system made to include Monthly Temperature Log being posted on front face of the Refrigerator. It will be replaced at the end of every month by the Charge Nurse. Placing the Log on front face of the refrigerator for easy visibility will allow licensed staff to view and recognize if daily log entry is missing. RN Charge Nurse will sign the completed monthly log before replacing a new log for the next month. 2. Daily after midnight, and at the end of each month, RN charge Nurse will check the Medication Refrigerator temperature and note the temperature on the Log. The nurse will determine if any entry is missing and complete Log. 3. Director of Nursing will in-service Nursing Staff on the new system of the Medication refrigerator monitoring Log. RN Supervisors will check daily that logs are completed and provide ongoing education to Licensed Nursing staff to maintain compliance. 4. Director of Nursing or designee will review logs monthly for completion. Compliance will be reported at the Quarterly QA Meeting	

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4 205	Continued From page 22	4 205		
4 205	11-94.1-53(b)(2) Infection control (b) The facility shall have provisions for isolating residents with infectious diseases until appropriate transfers can be made. (2) At least one single bedroom shall be designated as an isolation room as needed and shall have: (A) An adjoining toilet room with nurses' call system, a lavatory, and a toilet; (B) Appropriate hand-washing facilities available to all staff; and (C) Appropriate methods for cleaning and disposing of contaminated materials and equipment; This Statute is not met as evidenced by: Based on observations, staff interviews, and a review of facility's policy's and procedures, the facility failed to ensure the implementation of infection control techniques that prevent the development and transmission of communicable disease and infections as evidence by staff not disinfecting/cleaning a reusable blood pressure cuff, not properly disinfecting a stethoscope, and handling medications without gloves. In addition, the designated person responsible for the infection prevention and control program was not familiar with the state reportable disease list and policy. As a result of this deficiency, residents are at an increased risk of exposure to communicable diseases and infections. Findings include:	4 205	4205 11-94.1-53(b)(2) Infection Control 1)2) 1. Revision of DON job description to include roles of Infection Preventionist and Antibiotic Stewardship. Concurrently, facility is actively recruiting a dedicated Infection Preventionist Licensed Nurse to fulfill the requirements as outlined in CFR 483.80. 2. Director of Nursing will continue to assume responsibilities of Infection Preventionist and Antibiotic Stewardship until recruitment of dedicated personnel is completed. 3. Director of Nursing will follow Facility Policy and Procedures to ensure	4/10/20

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4 205	Continued From page 23 1) Review of the Infection Control Plan stated, "The infection preventionist or designee is ultimately responsible for the infection prevention program," and " Responsibility is delegated to the Director of Nursing/ Infection Preventionist (DON/DON) to carry out the daily functions of the infection control program. Those functions are described in the DON job description.. The DON/DON has knowledge of and interest in infection prevention." The plan also states, " ... the DON is responsible for ...communicating with the health department on any reportable diseases." 2) Review of the DON job description provided revealed there is no specific job duties or functions listed related to infection Control. The position summary does not include the delegated responsibility for the Infection Prevention Program or Antibiotic Stewardship Program (ASP). 3) On 02/20/20 at 02:07 PM during an interview, asked the DON who was responsible to report communicable diseases to the Department of Health and to describe the process. The DON stated, "I think the Administrator reports it." When asked the DON what required reporting, she was unable to verbalize the process and unaware the reportable diseases list was categorized by urgent and routine for reporting. DON said she had "just started at the facility nine months ago and working to organzie the infection control stuff." 4) Review of the policy titled "Reporting Communicable Diseases" revealed the policy did not identify who was responsible for reporting to the Department of Health, or what that process	4 205	compliance with Infection Prevention and Antiobiotic Stewardship. 4. Director of Nursing or designee will report compliance with Infection Prevention Program and Antibiotic Stewardship to Quarterly QA Meeting. 3)4)5) 1. Director of Nursing will report to Department of Health any reportable incidents of infection per HAR Title 11, Chapter 156. 2. All reportable identified infections will be recorded and tracked by Director of Nursing and reported at daily interdisciplinary team meetings to ensure all incidents are captured correctly. 3. Daily reporting of any incidents of infections will be done to the Director of Nursing and the interdisciplinary team to ensure all incidents are captured correctly. 4. Director of Nursing or designee will report compliance with reportable incidents of infection to Quarterly QA Meeting. 6)7) 8) 9) 1. Director of Nursing reviewed Policy and Procedure on Infection Prevention and Cross Contamination with RN-34, LPN-4 and CNA-53. Reeducation given to RN-34, LPN -4 and CNA-53 that all equipment such as stethoscope, blood pressure machine cuff needs to be disinfected after each resident's use. 2. Random staff observation will be conducted to ensure correct disinfection of equipment between resident use and for	

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4 205	Continued From page 24 was. 5) Cross Reference F881 6) On 02/20/20 at 07:45 AM, observed registered nurse (RN)34 and licensed practical nurse (LPN) 4 administering medication to R17 via G-tube. During the administration process, RN34 used a stethoscope given to him/her by LPN4 to auscultate placement of the G-tube directly on R17 abdomen prior to administering medications. After using the stethoscope, RN34 returned it back to LPN4 who then placed the stethoscope back into his/her scrubs pocket and proceeded to provide care to another resident. RN34 confirmed he/she did not disinfect the stethoscope prior to using it directly on R17's skin and could not confirm the stethoscope had been disinfected prior to use. LPN4 confirmed he/she did not disinfect the stethoscope RN34 used prior to placing the stethoscope back into his/her pocket. A review of the facility's policy and procedure documents "reusable items are cleaned and disinfected...between residents (e.g., stethoscopes, durable medical equipment." RN34 did not ensure the stethoscope was disinfect prior to use, in alignment with the facility's policy and procedure. Furthermore, LPN4 did not disinfect the stethoscope after use, before placing it back into his/her pocket. 7) On 02/20/20 at 08:00 AM, observed LPN4 unplug a blood pressure machine, with a reusable cuff, from the outlet in the hallway, take R85's	4 205	compliance with Infection Control Policies and Procedures. Compliance with Infection Control will be included in all Nursing Staff Annual Competencies. 3. RN-34, LPN-4 and CNA-53 will watch Infection Prevention video and pass competency exam. CNA-53 will do GT dressing changes and be observed for skills and competency compliance. RN-34 will use gloves for medication splitting to prevent infection transmission. Observation of RN-34 will include competency checklist compliance. Director of Nursing will in-service All Nursing Staff for Infection Prevention and Cross Contamination as part of their annual competency and skills requirement. Education will be ongoing to include any newly hired nursing staff. 4. Director of Nursing or designee will monitor nursing staff education tracking tool to ensure all Nursing Staff are complying with annual competencies and skills checks for Infection Prevention and Cross Contamination. Compliance data will be reported to Quarterly QA Meeting.	

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4 205	Continued From page 25	4 205		

blood pressure, put the machine back in the hallway to be used again, and proceed to provide care to another resident.

LPN4 confirmed the blood pressure cuff was not disinfect prior to or after obtaining R85's blood pressure and placing it back into the hallway.

A review of the facility's policy and procedure documents "reusable items are cleaned and disinfected...between residents (e.g., stethoscopes, durable medical equipment." LPN4 did not clean and disinfect the blood pressure machine according to the facility's policy and procedure.

8) On 02/20/20 at 08:15 AM, observed RN34 preparing medication for R113. R113 has an order for Calcium 500 mg tablet, oral administration, with instructions to cut the tablet into four pieces. RN34 did not use gloves while handling the medication when splitting the pill. RN34 confirmed medications should not be handled without gloves.

A review of the facility's policy and procedure "Specific Medication Administration Procedure: Oral Medication Administration", documents staff should avoid touching the tablet, unless staff dons gloves.

9) A review of Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/19 documented R66 was admitted to the facility on 01/05/2018. R66 has a diagnoses of Hypoxia; Persistent Vegetative State; Tracheostomy; Gastrostomy; Spastic Quadriplegia; Osteopenia; and a history of multiple Cerebral Vascular Infarction.

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4 205	Continued From page 26 On 02/21/20 at 11:44 AM, observed certified nurse aide (CNA)53 changing R66's G-tube dressing. Observed CNA53 holding part of the dressing in his/her gloved left hand, pull out a scissors from his/her pocket and cut the tape (which was attached to the dressing) with his/her un-gloved right hand. CNA53 used his/her un-gloved hand to place the dressing around the G-tube site. Observed CNA53's hand come into direct contact with R66's skin. A record review documented, on 01/30/20, R66 was ordered Doxycycline 100 mg via G-tube twice daily for two weeks die to a G-Tube site infection. The Director of Nursing (DON) confirmed CNA53 did not adhere to the facility's infection control policy's and procedures, CNA53 should don gloves while changing a G-tube dressing. Furthermore, the DON stated staff should set up an area to for supplies as opposed to storing dressing supplies in his/her pocket. Also, staff should label(date and initial) the dressing prior to placing the dressing on the resident.	4 205		

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4 205	Continued From page 27 Based on observations, staff interviews, and a review of facility's policy's and procedures, the facility failed to ensure the implementation of infection control techniques that prevent the development and transmission of communicable disease and infections as evidence by staff not disinfecting/cleaning a reusable blood pressure cuff, not properly disinfecting a stethoscope, and handling medications without gloves. In addition, the designated person responsible for the infection prevention and control program was not familiar with the state reportable disease list and policy. As a result of this deficiency, residents are at an increased risk of exposure to communicable diseases and infections. Findings include: 1) Review of the Infection Control Plan stated, "The infection preventionist or designee is ultimately responsible for the infection prevention program," and " Responsibility is delegated to the Director of Nursing/ Infection Preventionist (DON/DON) to carry out the daily functions of the infection control program. Those functions are described in the DON job description.. The DON/DON has knowledge of and interest in infection prevention." The plan also states, " ... the DON is responsible for ...communicating with the health department on any reportable diseases." 2) Review of the DON job description provided revealed there is no specific job duties or functions listed related to infection Control. The position summary does not include the delegated responsibility for the Infection Prevention Program or Antibiotic Stewardship Program (ASP).	4 205		

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4 205	Continued From page 28 3) On 02/20/20 at 02:07 PM during an interview, asked the DON who was responsible to report communicable diseases to the Department of Health and to describe the process. The DON stated, "I think the Administrator reports it." When asked the DON what required reporting, she was unable to verbalize the process and unaware the reportable diseases list was categorized by urgent and routine for reporting. DON said she had "just started at the facility nine months ago and working to organzie the infection control stuff." 4) Review of the policy titled "Reporting Communicable Diseases" revealed the policy did not identify who was responsible for reporting to the Department of Health, or what that process was. 5) Cross Reference F881 6) On 02/20/20 at 07:45 AM, observed registered nurse (RN)34 and licensed practical nurse (LPN) 4 administering medication to R17 via G-tube. During the administration process, RN34 used a stethoscope given to him/her by LPN4 to auscultate placement of the G-tube directly on R17 abdomen prior to administering medications. After using the stethoscope, RN34 returned it back to LPN4 who then placed the stethoscope back into his/her scrubs pocket and proceeded to provide care to another resident. RN34 confirmed he/she did not disinfect the stethoscope prior to using it directly on R17's skin and could not confirm the stethoscope had been disinfected prior to use. LPN4 confirmed he/she did not disinfect the stethoscope RN34 used prior	4 205		

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4 205	Continued From page 29	4 205		

to placing the stethoscope back into his/her pocket.

A review of the facility's policy and procedure documents "reusable items are cleaned and disinfected...between residents (e.g., stethoscopes, durable medical equipment." RN34 did not ensure the stethoscope was disinfect prior to use, in alignment with the facility's policy and procedure. Furthermore, LPN4 did not disinfect the stethoscope after use, before placing it back into his/her pocket.

7) On 02/20/20 at 08:00 AM, observed LPN4 unplug a blood pressure machine, with a reusable cuff, from the outlet in the hallway, take R85's blood pressure, put the machine back in the hallway to be used again, and proceed to provide care to another resident.

LPN4 confirmed the blood pressure cuff was not disinfect prior to or after obtaining R85's blood pressure and placing it back into the hallway.

A review of the facility's policy and procedure documents "reusable items are cleaned and disinfected...between residents (e.g., stethoscopes, durable medical equipment." LPN4 did not clean and disinfect the blood pressure machine according to the facility's policy and procedure.

8) On 02/20/20 at 08:15 AM, observed RN34 preparing medication for R113. R113 has an order for Calcium 500 mg tablet, oral administration, with instructions to cut the tablet into four pieces. RN34 did not use gloves while handling the medication when splitting the pill. RN34 confirmed medications should not be

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4 205	Continued From page 30 handled without gloves. A review of the facility's policy and procedure "Specific Medication Administration Procedure: Oral Medication Administration", documents staff should avoid touching the tablet, unless staff dons gloves. 9) A review of Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/19 documented R66 was admitted to the facility on 01/05/2018. R66 has a diagnoses of Hypoxia; Persistent Vegetative State; Tracheostomy; Gastrostomy; Spastic Quadriplegia; Osteopenia; and a history of multiple Cerebral Vascular Infarction. On 02/21/20 at 11:44 AM, observed certified nurse aide (CNA)53 changing R66's G-tube dressing. Observed CNA53 holding part of the dressing in his/her gloved left hand, pull out a scissors from his/her pocket and cut the tape (which was attached to the dressing) with his/her un-gloved right hand. CNA53 used his/her un-gloved hand to place the dressing around the G-tube site. Observed CNA53's hand come into direct contact with R66's skin. A record review documented, on 01/30/20, R66 was ordered Doxycycline 100 mg via G-tube twice daily for two weeks die to a G-Tube site infection. The Director of Nursing (DON) confirmed CNA53 did not adhere to the facility's infection control policy's and procedures, CNA53 should don gloves while changing a G-tube dressing. Furthermore, the DON stated staff should set up an area to for supplies as opposed to storing dressing supplies in his/her pocket. Also, staff	4 205		

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4 205	Continued From page 31 should label(date and initial) the dressing prior to placing the dressing on the resident.	4 205		
4 218	11-94.1-55(e) Housekeeping (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair. This Statute is not met as evidenced by: Based on observations, staff interviews, and reviews of facility records and policy's and procedures, the facility failed to provide a safe environment for Resident (R)108 as evidence by an actuator valve on the air conditioner breaking that caused water damage and ceiling tile to break in Room 413. As a result of this deficiency, the resident was at risk for potential serious harm and/or a negative outcome. Findings include: R108 was admitted on 01/21/20 with hospice services. At the time of the incident, R108 was in bed resting while on 2 Liters of oxygen via nasal cannula. A review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 01/28/20, documented R108 requires extensive assistance with 2+ person physical assist to transfer between surfaces including to or from: bed, chair, wheelchair, standing position and is totally dependent on staff to move throughout the unit. On 02/18/20 at 12:16 PM, observed a water soaked ceiling tile in Room 413. The tile bowed from the ceiling with a steadily medium flow of water dripping down into the room and splashing onto R108's oxygen machine. R108 was in bed	4 218	4218 11-94.1-55(e) Housekeeeping 1. Resident R108 was moved immediately to another room to prevent further exposure to the identified hazard. The air conditioning service contractor responded on 02/18/20 to assess the problem. A repair quote was prepared, submitted, and approved to replace the leaking water valve and non-working AC power head actuator unit. The air conditioning service contractor completed replacement of the defective unit on 02/20/20. new ceiling tiles were placed, and room was thoroughly cleaned following completion of all maintenance work. 2. Facility maintenance personnel conducted a thorough inspection of all air handler units in the facility on 03/20/20. They identified all items that appeared to be worn or leaking. As identified by the air conditioning service	4/10/20

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4 218	Continued From page 32 approximately 2 feet away from the dripping water. An adjacent tile also had apparent signs of water damage. Staff relocated to another room right before the ceiling tile broke and approximately 1 to 2 gallons of water poured into a trash can maintenance staff supplied. When the tile broke, observed a pink plastic bin (used in patient care) fall from the ceiling (along with the ceiling tile and water). Staff confirmed if R108 had visitors at the time, the visitor would most likely be situated under the damaged ceiling tiles. Inquired with the Maintenance Supervisor (MS) regarding the plastic bin that fell from the ceiling. MS stated that the plastic bin had probably been placed in the ceiling to catch dripping water, which was most likely dripping from the AC actuator valve. MS stated the plastic bin was probably used by the contracted AC repair staff, which the contracted AC repair company received from the facility, to which MS denied knowledge that the plastic bin was being used in the ceiling to catch water. MS stated the air conditioner (AC) in Room 413 had been previously serviced, however, MS was unable to recall when the AC any detail information. Requested a copy of the facility work order and documentation from company that previously serviced the AC. On 02/24/20 at 11:50 AM, MS confirmed he did not have any documentation related to previous repair/services related to the AC in Room 413. On 02/18/20 at 01:45 PM, inquired with 4th floor unit clerk and staff regarding the process of work orders and review of previously requested work orders. A search of the work orders provided for 2020 and 2019 did not include a work order related to the AC unit located in Room 413. Unit staff confirmed the AC unit in Room 413 had not been serviced in 2020 or 2019.	4 218	contractor, the AC power head actuator units are manufacturer-sealed components that cannot be accessed and/or repaired by facility maintenance personnel. Recommendation is for facility maintenance to do routine AC system preventative maintenance checks for leaks in the surrounding actuator areas quarterly. Any leaks may indicate failed packing and/or failed actuator, at which time a service call must be placed by the Maintenance Supervisor to the contractor for further evaluation and repair if necessary. 3. The AC preventative maintenance form has been revised to reflect air handler actuator leak checks and complete leak assessments for each unit on a quarterly basis. Additionally, facility maintenance will include visual checks for leaks on their daily walkthrough of the building. This includes all resident rooms, hallways, storerooms and dining areas. Any noted issue will be reported to the AC service contractor by the Maintenance Supervisor. Any resident near an area of concern or danger will be immediately relocated for personal safety. The Maintenance Supervisor reviewed with all staff on 04/09-10/20 the facility policy and procedure for reporting maintenance issues, including the written service request forms located at each nurses' station.	

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4 218	Continued From page 33 On 02/21/20 at 08:00 AM, inquired with the Administrator regarding documentation of contracted and/or in-house service to the AC in room 413. The Administrator provided the quarterly "Air Conditioning Prevention Maintenance Form" completed in January 2020 for Room 413 which checks: operating conditions; check the pan; clean as needed; apply air to drain; place tabs into pan; change filter; and clean coil if needed. Administrator confirmed a visual inspection of the AC unit and various other components is required to complete the Air Conditioning Maintenance form. Inquired with MS regarding the visual inspection of Room 413 AC unit, the lack of discovering the plastic bin used to catch water, and the accuracy of the quarterly AC prevention checks. MS was unable to provide a response to the inquiry or produce any other documentation of any services for the AC in Room 413. A review of the facility's policy's and procedure for maintenance "Service Request" documents the procedural steps for staff to follow regarding maintenance request. Per the facility's policy and procedure, staff is to fill out a request form with pertinent information, service request is then clipped on the maintenance clipboard at the nurse's station and notify the Environmental Service Coordinator if immediate attention is required, after the completion of the request the form will be signed and stored in the maintenance shop for future reference. MS confirmed there was no documentation of the service request on the clipboard at the nurse's station or in the maintenance shop.	4 218	4. The Maintenance Supervisor will maintain the facility preventative maintenance inspection logs and repair records for all AC equipment in the facility. The Maintenance Supervisor will report compliance with inspections and repair items to the quarterly QA Committee meetings.	